

treatment of this class of cases. And despite the grave character the case assumed after the second injury, I think there is great reason to hope that, with the use of the elevated shoe and crutches, without which he could not get out of doors, and with a proper regimen, he will yet recover without resection, and with little or no deformity.

The advantages which the mechanical treatment here described possesses over that commonly employed in the management of hip-joint disease are—

1. It saves the surgeon the trouble and annoyance of applying and carefully watching the instruments in ordinary use, to see that proper extension is kept up and undue pressure prevented, while the patient's comfort is greatly promoted by dispensing with adhesive plasters which irritate the skin and require removal from time to time, and also with the perineal band, which is a constant source of discomfort.

2. The spasmodic contraction of the peri-articular muscles is overcome by the gentle, persuasive, and painless (physiological) extension made by the weight of the limb for several hours each day, whilst forcible extension, either by the ordinary portative instruments, or by the weight and pulley, irritates the muscles and stimulates them to resistance and contraction, which must be overcome by main force.

3. I am quite confident, judging from the experience thus far obtained, that the plan of managing coxalgia herein described, will shorten its duration more decidedly than can be done by the older methods of treatment.

4. The apparatus (if so simple a thing deserves the name of apparatus) is inexpensive, and can be made by any ordinary mechanic.

I may add, in conclusion, that I hope at some future time to publish my experience with the method of extension here described in the treatment of inflammation of the knee and ankle-joints, to which it is quite as applicable as to diseases of the hip-joint.

ARTICLE V.

LATE HEREDITARY SYPHILIS.¹ By I. EDMONSON ATKINSON, M.D.,
Physician to the Baltimore Special Dispensary.

M. B., white, sixteen years old, and born in Baltimore, was brought to my office by my friend, Dr. Samuel Theobald, to whom she had applied for treatment for her eyes May 27, 1878. She is of medium height, of slender frame, and well proportioned. Her complexion is fair, eyes blue, and hair light in colour. Her parents are both living, and she has a brother and sister, the former four years older, the latter two years younger than herself. She menstruated for the first time last fall, and

¹ Read before the Baltimore Clinical Society, Nov. 1, 1878.

has been regular ever since. Until her ninth year she was rather delicate, but thinks her health was moderately good (as also does her mother, who accompanied her). Her most severe illness up to that time was an attack of measles during her seventh year. During her ninth year she was first troubled with sore throat, which became so severe that she was obliged to leave school. For this she was treated by a physician, who applied caustics to her throat, and used other remedies. In spite of this, however, it was only after several years that this trouble yielded. Somewhat more than two years ago, she had soreness and ulceration of the roof of her mouth, and at this time some small pieces of bone were discharged from her mouth, and came, as she says, from her hard palate. She does not know when this got well. Two years ago a pimple appeared upon the left side of the upper lip, just under the ala of the nose. At the end of two weeks, and when no larger than a split pea and covered with a scab, this was cauterized by her physician. After this, ulceration proceeded with great rapidity, and extended towards the left ala nasi, which soon became invaded, as likewise the nasal septum. The tip of the nose was next involved, and in a short time the ulcer covered the other side of the nose and both cheeks. During this time the disease spread continuously, and no new foci of ulceration were developed. As well as she can recollect, at no time have there been papules or tubercles around the edges of the ulceration. At the end of a year the nasal septum had been entirely destroyed, and small pieces of bone were discharged from the nasal cavity. Cicatrization had begun previous to last summer, and before the autumn was complete over the nose and left cheek. While cicatrization was occurring in these parts, there was steady but irregular extension of the ulceration in other parts of the face. During the past winter the lids of both eyes became involved, and the forehead has been invaded only during the past few weeks. Many remedies have been employed, all, she thinks, without benefit, except the white precipitate ointment, which she has been using since last fall at the instance of a friend.

Her present condition is as follows, viz., the entire face from just in front of both ears, extending superiorly to the lower half of the forehead and inferiorly to a point below the chin, is occupied by a circular surface, made up of areas of ulceration and of scar tissue, the latter covering the cheeks and nose, and forming more or less irregular bands and rugosities. The nasal bones preserve to a great extent the normal shape of the upper portion of the nose, but the alæ are almost completely flattened to the level of the cheeks; the nostrils have been replaced by two very minute holes, hardly large enough to admit pin heads, and almost useless in the respiratory act. The mouth is distorted, and its orifice narrowed. To the right of the chin is an ulcerating surface, said to be of about six months' duration; this surface is bounded externally very sharply from the healthy skin by a ridge of granulating tissue. The ulcer itself is red and granulating, but little excavated, and discharging a small amount of thin pus. Several ulcers are here grouped together; the largest one is of irregular outline, and five cm. in diameter; near this are several small oval ulcers. The eyes, which became affected early last winter, the right one first, present a really hideous appearance. The upper and lower lids of both eyes have been extensively destroyed by the ulceration, so that neither eyeball can be covered perfectly. The lids are much thickened, their edges are red, glazed, and raw; the lashes are for the most part absent. The conjunctivæ are swollen and inflamed. Both corneæ are

cloudy, and upon the right one is a small ulcer. The orifices of the lachrymal canals have been obliterated, and the tears trickle over the cheeks.

Upon the forehead, arranged in a semicircle, just above the nose, are four small ulcers, the lowest one as large as a split pea, red, granular, and excavated, the others causing a slight prominence of the skin, and quite small. These are separated by areas of healthy skin, and have appeared only within the month. Outside of the well-defined margin of cicatricial tissue upon the cheeks, there are no morbid conditions; the same may be said of the ulcers near the chin. Nowhere are there papules or tubercles present. There is some enlargement of the submaxillary glands, which sometimes become tender, but have never suppurated.

Examination of the buccal cavity shows cicatricial tissue extending over the hard palate, which is deeply arched. Just behind the upper middle incisors is a deep pit in the bone, which is now imperforate, but is doubtless the site of the old loss of substance. Proceeding backwards towards the pharynx, cicatricial bands are everywhere visible. The uvula has been entirely destroyed, and the anterior pillars are adherent to the posterior wall of the pharynx. At present there is no ulceration in these parts. The central upper incisor teeth are perfect, but there is some irregularity in the arrangement of the other incisors. None of the teeth are peg-shaped. The conformation of the head is not suggestive of abnormal conditions. Ulceration has destroyed all other specific modifications of the physiognomy, if, indeed, any ever existed.

The general health of the patient is now pretty good; and her mother says that with the exception of the attack of measles she has had no other cutaneous eruptions than those noted; neither have there been periosteal thickenings, or rheumatoid pains, nor are there other scars of lesions upon other parts of her body. Her urine is free from albumen and tube casts.

Her mother has never miscarried, and has two other children—a son four years older than my patient, who is said to be perfectly healthy, and a daughter fourteen years old, whom I have seen, and who is apparently perfectly healthy. The mother, however, has around her mouth several circular scars, which she attributes to sores many years ago. The father is subject to an eruption upon his face, which has been called erysipelas, but which gives rise to scars, and which he has had ever since he was in the army during the late war. While in the army he had an extensive ulceration upon his shoulder. He has suffered much from “rheumatism,” and is always ailing and unable to work. (The information concerning the husband and father was obtained from his wife and mother; the man himself has persistently evaded me, and has avoided an examination.) There can be but little doubt, then, that the girl's father was already during the war the victim of somewhat advanced syphilis.

From the statements of the patient and her mother, it seems probable that her lesions had been treated by her physicians as manifestations of lupus; at all events, there was no history of the administration of mercury or of iodine; but, upon the other hand, frequent cauterizations had been employed. (It will be remembered that the white precipitate ointment, which had been used for some months, had been recommended by a non-professional person.) There could, evidently, be here only the question of syphilis or of lupus in the formation of a diagnosis. From the fore-

going description it will be at once remarked that the lesions presented were strongly suggestive of lupus; the superficiality of the ulceration, its red and but slightly secreting surface, more closely resemble lupus than syphilis.

Upon the other hand, there was the history of a very much more rapid ulceration than is observable in lupus, the face being almost entirely invaded within two years after the appearance of the tubercle upon the upper lip; again, the cutaneous ulceration was preceded by a pharyngeal ulceration, which had begun five years previously, a pathological succession not observed in lupus, since the lupous affections of the mouth and fauces are only met with "in association with cutaneous lupus, either as a direct continuation from the skin of the cheeks and lips, or independently." (Kaposi, *Hebra, Dis. of Skin*, New Sydenham Society's Translation, vol. iv. p. 70.) Another important point of difference was the destruction of bony tissue in this young woman, both of the hard palate and of the nasal cavity. Destruction of bone is certainly a rare occurrence in lupus. Kaposi does not recollect to have seen "secondary inflammation of the submucous tissue ending in caries or necrosis of the bones of the hard palate, and perforation extending through into the cavity of the nose, nor necrosis of the vomer in consequence of lupus of the mucous membrane of the nose."

There was, furthermore, the history of suspicious ulcers upon the mother's face, and the clear history of symptoms in the father, dating back many years, and almost without doubt due to syphilis.

Actuated by these considerations, I formed a diagnosis of syphilitic ulceration; and in view of the early age at which symptoms, usually held to be late manifestations of the disease, exhibited themselves; the absence of other symptoms of the earlier stages; the modified character of the lesions observed, contrasting markedly with the ulceration of the same parts in the acquired disease; and the probably late stage of the disease in the father about the time of her birth, I concluded that these lesions derived their origin from an inherited taint. The correctness of this conclusion will, I think, presently appear.

Acting, then, upon this diagnosis, treatment of an antisymphilitic nature was immediately begun. The white precipitate ointment was ordered to be continued as a local application, and there was ordered a mixture containing 8 grains of potassium iodide with 20 minims of the syrup of the iodide of iron in a tablespoonful of water three times daily. After a week the dose of the iodide was increased to 15 grains, and after this no change in treatment was made until an entire cure had been effected. By June 24th the ulcers upon the forehead were entirely healed, and during the first week in July those upon the lower parts of the face were well. The eyes were much better, although the swelling and loss of substance rendered it impossible to completely close the lids. After this time, considering herself well, she became irregular in her attendance; but when last seen the left eye was very much better, and could be closed by a determined effort; the right eye still remained inflamed with excoriated, thick-

ened lids, not sufficient to cover the eyeball. She was ordered to continue her medicine.

Here, then, was a case where the face was converted into a repulsive scar; where a young woman of sixteen years will be condemned, during the rest of her life, to hide her countenance from her fellow creatures; where a happy future has been rendered absolutely impossible by a malady, whose early recognition would almost certainly have resulted in a prompt and complete arrest, and in the preservation of her features in their integrity. Here, also, the characters of the symptoms might have indicated the nature of the disease, or at least have suggested that *experimentum crucis*, an antisiphilitic treatment.

Under these circumstances it may be worth while to draw attention to some peculiarities of that form of hereditary syphilis denominated "tardy," more especially to the tendency of the disease in this stage to attack the pharynx and fauces, the bones of the hard palate and nasal cavity and the contiguous parts. It is a disputed question whether syphilis *hereditaria tarda* may appear without the patient ever having had, during infancy, any evidences of the disease; whether, in a word, hereditary syphilis may appear for the first time after the period of infancy. There are distinguished authorities who believe that such may be the case. Van Buren and Keyes, *Genito-Urinary Diseases with Syphilis*, page 662, say, "That there may have been some undiscovered symptom in babyhood may be allowed, but still it is as near a certainty as possible, without absolute proof, that a child of a parent whose syphilis has nearly run out, may show no signs of disease until many years after birth, and then the lesion will be of a bone, a joint, a gland, the eye, or perhaps there will be a patch on the mucous membrane of the buccal cavity, an ulcer of the nose resembling lupus, or some other single localized lesion usually passing undiagnosed as far as its etiology is concerned." On the other hand, A. Weil (Ueber den gegenwärtigen Stand der Lehre, von der Verebung der Syphilis: *Sammlung Klinischer Vorträge*, etc.) declares that the occurrence of inherited syphilis manifesting itself for the first time after years, or at the time of puberty, is just as questionable as the occurrence of tertiary symptoms in acquired syphilis without the previous manifestation of the primary affection, or of that of the secondary period.

Although the literature of late hereditary syphilis is scanty, and the relations of the affection but imperfectly known, there are a number of cases recorded where as far as was discoverable the first symptoms were observed after puberty. Bäumler, Weil, and others, however, doubting the possibility of this, call attention to the, occasionally, very insignificant manifestations of infantile hereditary syphilis, and to the great probability of their being overlooked. Naturally, an insignificant lesion is most apt to pass unnoticed or to be forgotten; and the most that can be said at the present time is that *late hereditary syphilis, even of very grave character,*

may occur in individuals, who, during infancy, suffered from symptoms of their inherited disease, so mild and unimportant as to escape recognition.

The symptoms of late inherited syphilis usually resemble those of a modified tertiary form of the acquired disease, but have also, undoubtedly, been treated of by many writers, as manifestations of the scrofulous diathesis. It is, however, the opinion of writers of the most experience, that the differences between late hereditary syphilis and scrofula are positive. Hutchinson, for instance, asserts without hesitation that hereditary syphilis "neither predisposes to consumption nor to the ordinary forms of scrofulous and tubercular disease."

It is, however, not my intention to speak of the various lesions of the stage of the disease under discussion, but merely to draw attention to a set of symptoms whose actual presence, or the cicatricial remains of whose former presence in children and young persons not known to be syphilitic, should always arouse the suspicious watchfulness of the medical man. There are usually evidences of past or present disease which are well known, to betray the syphilitic inheritance of certain persons; there may be the peculiar notched upper central permanent incisor teeth, the interstitial keratitis or its vestiges, the flattened bridge of the nose, the linear cicatrices about the mouth, the protuberant forehead. There is also usually the history of syphilis in infancy. All these sources of information may, however, be absent, and we may be obliged to look for other signs to throw light upon our perplexities. When, therefore, a patient who has never had acquired syphilis presents destructive lesions, or their remains, of the pharynx and fauces, of the hard and soft palates, or of the nasal cavity, the probability that he has to do with inherited syphilis should suggest itself to the medical attendant.

A review of the recorded cases of late hereditary syphilis reveals an astonishingly large proportion of lesions of the character just referred to. Lancereaux (*Traité Historique et Pratique de la Syphilis*, Paris, 1873, p. 436), in quoting cases of hereditary syphilis of late development reported by various authors, such as Balling, Trousseau, Fournier, Sperino, Sigmund, Ricord, Bouchut, and others, records a large majority in whom the destructive lesions or their scars implicated the pharynx, the hard and soft palate, and nasal bones. Several of these cases likewise presented destructive ulceration of the face. Cases have also been reported by Laschkewitz (*Vierteljahr. für Dermatologie und Syphilis*, Heft. 2, 1878), Klink (quoted in the same Journal), Zeissl (*Pest. Med. Pr.*, Jan. 1877), Wilks (*Lancet*, Feb. 19, 1876), Lewin (*Wien. Med. Presse*, No. 1, 1876), and others. In a paper read before the Société Nationale de Médecine de Lyon (*Lyon Médicale*, July 16, 1876), M. Dron related fifteen cases of late hereditary syphilis in whom naso-pharyngeal symptoms were the lesions most commonly encountered. Lancereaux declares that he finds himself more and

more disposed to consider those affections described under the name *angina scrofulosa*, purely tardy manifestations of hereditary syphilis. Chaboux (*Certain Lesions of the Naso-pharyngeal Region which should be attributed to Syphilis*, Thèse de Paris, 1875) "concludes that late tertiary syphilis, particularly the hereditary forms in children and adults, is far more common than is generally supposed; that the naso-pharyngeal region is its site of election; that suppurative osteitis of the nasal and palatine bones, with ulceration of the velum, isthmus, and pharynx, as well as certain forms of tubercular lupus, limited to the *alæ nasi* and septum, should not too hastily be attributed to struma" (*Archives of Dermatology*, April, 1878).

Van Buren and Keyes (*Genito-Urinary Diseases and Syphilis*, page 599) remark, "It has been written that scrofula may cause these throat ravages in children; because children are found in whom a syphilitic history or parentage cannot be traced, who have ulcers and other evidences of so-called scrofula and destructive ulceration of the soft palate, perhaps, not so promptly relievable by the iodide of potash as similar fresh conditions in the adult. Yet the iodide of potassium is usually given for these cases, and with benefit."

Zeissl, who believes that in these cases of late hereditary syphilis, the taint is derived from the father, in whom the symptoms of the disease were latent at the time of impregnation, says that the children may be born and remain during their years of infancy apparently healthy, but that gradual gummous infiltrations appear upon the skin (*lupus syph. hered.*), with accompanying destruction of the soft palate and of the nose (*ozæna syph.*), enlargement of the bones, etc., appearances which, in former times more frequently than at present, were considered manifestations of scrofula (*Lehrbuch der Syphilis*, 1871, p. 304).

It seems quite certain then that there is a special predisposition towards ulcerative lesions of the pharynx and soft palate, and of the bones of the hard palate and nasal cavity, in persons suffering under the taint of hereditary syphilis; and the practical conclusion to be drawn from this circumstance is, that in all cases involving lesions of these parts where the question of acquired syphilis may be excluded, and even where other signs of inherited syphilis may be wanting, the employment of anti-syphilitic treatment should not be held in reserve as a last resort, but, on the contrary, its prompt and vigorous exhibition should be immediately decided upon and persistently continued, in the strong hope that by so doing, such repulsive deformities as have occurred in my case may be averted, and the patient quickly relieved of an almost interminable source of suffering and mortification.

This treatment may with all the more confidence be resorted to where destructive lesions of the mucous membrane of the parts under discussion have occurred without or previous to cutaneous lesions, and where losses

of bony substance have taken place in the palatal and nasal regions; since lupus, the affection offering the strongest resemblance to the effects of syphilis upon these parts, is only met with in these localities, in association with cutaneous lupus, either as a direct continuation from the skin or independently, and since destruction of osseous tissue by lupus is, to say the least, exceedingly uncommon.

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ARTICLE VI.

EXCISION OF A LARGE FEMORAL CYST; GENETIC ORIGIN OF SUCH CYSTS FROM CONGENITAL PERITONEAL POUCHES. By MIDDLETON MICHEL, M. D., Prof. of Physiology and Histology in the Medical College of the State of South Carolina, Charleston.

THIS report of a cyst of the thigh of considerable size, which came under my care some years ago, with another exactly similar recently under my observation in the practice of a colleague, is of surgical interest, since there are but few of like character on record. As my special object, however, is to furnish an explanation of the possible origin of these growths, which it appears is involved in such obscurity as to be passed over without reference, or attempted to be accounted for by the vaguest hypotheses, I shall make their probable mode of development the principal topic of remark, without intruding a dissertation on the pathology of cystgenesis, with a tiresome repetition of particulars that are perfectly well understood.

CASE I.—A negro man, aged-fifty years, a servant of Mrs. Charlotte K., of this city, came under my professional care many years ago. He presented a cystic tumour of great size, occupying the entire inner portion of the right thigh from below Poupart's ligament to within a few inches of the knee-joint. In circumference the tumour measured around the thigh in its greatest transverse direction about thirty inches, was almost spherical in shape, and presented fluctuation.

It had never been tapped, and had grown slowly from a tumour of the size of a walnut to its then inordinate dimensions. Giving no pain, this tumour became the subject of complaint only when through its size free locomotion was impaired. He was operated upon in the amphitheatre of the medical college in presence of the class. An extensive incision was required which was practised in a longitudinal direction almost parallel to the course of the femoral artery along the inner border of the cyst from Poupart's ligament to within the neighbourhood of the knee-joint.

The isolation of the cyst at its inner, anterior, and outer portions, though requiring careful dissection not to perforate the sac, was easily accomplished; but its adherence at its under part was so intimate with the deeper tissues and sheaths of the vessels and nerves as to constitute the most difficult, perhaps dangerous part of the operation, as it certainly was the most protracted part of the procedure. It rested upon and dipped deeply